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Engendering Social Security and Protection: The Case of Africa

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- Most Africans have no access to any social protection mechanisms. Women are particularly disadvantaged since they work predominately in the informal economy. The social security mechanisms that do exist are mostly gender-blind.

- HIV/AIDS and globalisation are rapidly weakening the extended family system, which has traditionally been the source of social security for many. The provision of effective social protection is hence becoming increasingly important and can play an empowering role in African societies and a stimulating role in African economies.

- The highly informal structure of many Sub-Saharan African countries gives little room for universal social protection schemes. Social security schemes supported by the few formal sector workers are not sustainable in the long term. Poor tax regimes have resulted in high donor dependency. African countries need to explore appropriate financing mechanisms. With high poverty levels, tax (on luxury goods) appears to be an appropriate mechanism to ensure the poor are paid for by the rich.

Dialogue on Globalization

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1. High Informality, High Vulnerability

The majority of Africa's population live in rural communities and are trapped in informal sector employment. The informal sector in Africa is characterised by poor working conditions and lack of job security and social protection. It is also dominated by women and young people. Women constitute the majority of informal sector operators in Ghana (57 %), Benin (65 %), Malawi (58 %), and Namibia (53 %) (Baah 2007). Women are also engaged in vulnerable employment positions such as domestic work and casual employment, where social security coverage is close to zero.

The need for social protection mechanisms in Africa is underscored by rising vulnerability. There is pervasive unemployment, volatile food prices, war and conflicts, as well as environmental disasters, all of which require safety nets. A high prevalence of HIV/AIDS contributes to the rising number of orphans and families headed by women and children. Globalisation, with it associated urbanisation, is rapidly weakening the extended family system, which has traditionally been the source of social security for many.

Vulnerability to shocks varies significantly, and the impacts of shocks may affect men and women differently. Some risks (e. g., maternity) are biologically imposed. Other risks, even if they are not biologically imposed, can be higher for women than men – they are biologically susceptible to some illnesses such as certain sexually transmitted diseases and HIV and have gender-specific health issues, such as those related to child-bearing.

Global changes in the labour market, macroeconomics, and demographic transitions are resulting in negative impacts on women, particularly those outside the formal sector (Sabates-Wheeler and Kabeer 2003: 6). The banking crisis and credit squeeze that followed the global economic crisis affected women greatly, as they are the main clients of microfinance institutions in Africa. A decline in demand for exports affected the incomes of women in high-value agriculture (e. g., Uganda) (Buvinic 2009). Evidently, poverty has increased in female-headed households compared to male-headed households.

2. The Focus on Employment: a Disadvantage for Women

Social protection programmes in most African countries are gender-neutral in spite of the differential impacts of risk on men and women. They are mainly employment-based social protection programmes focussing on formal sector workers, hence excluding the majority of women, who are concentrated in the informal sector. In Ghana in 2009, females constituted 29 per cent of the Social Security and National Insurance Trust's active contributors and 14.9 per cent of its beneficiaries (SSNIT Annual Report 2009). The female membership in the National Social Security Fund in Kenya remains at 25 per cent. Contingencies covered are traditionally old age and related benefits, such as survivor and disability benefits. Maternity leave is largely instituted as an employer liability, while support for families with children is rare on the continent.

Gendered social protection programmes are particularly important in African countries, where traditional customs relegate women to the background. In some African societies (e.g., northern Ghana), women have limited access to property, such as land and livestock. In some societies, families continue to prioritise boys over girls in education, resulting in many women lacking the skills and capacities to compete on the labour market. Yet, little attention is given to gender in the design of social protection programmes in Africa.

Since 2000, some African countries have attempted to reform existing programmes and introduce new ones. The primary focus has been to improve benefits (e. g., Nigeria and Ghana) and/or expand coverage to the informal sector (e. g., Ghana). A few of these new/reformed programmes have entrenched positive discriminative objectives that favour women, but others have eliminated existing gender biases. South Africa has set the pension age of men and women to 60 years, eliminating the gender-bias in favour of women.[1]

Social assistance programmes are also being established on the continent. Cash transfers are being delivered to the elderly, people living with disability, and the destitute. Aside from Botswana, Mauritius, Namibia, and

1. In 2008 South Africa amended its pension laws to lower the qualifying age for men from 65 to 60 years.

South Africa, which offer comprehensive social assistance programmes, Lesotho and Seychelles have introduced universal pension schemes, while Cape Verde, Liberia, and Swaziland, among others, have embraced means-tested old age pension schemes. Ghana, Mozambique, Sierra Leone, Uganda, and Zambia, among others, have initiated pilot programmes to extend cash transfers to the elderly and vulnerable. Health insurance schemes have also been instituted by some countries.

3. Social Protection Contingencies Covered in Sub-Saharan Africa

Social protection programmes and policies in most African countries have not changed much from those inherited from the colonial governments. The focus has primarily been on providing emergency aid in the form of food, cash, and in kind donations, as well as in the form of humanitarian assistance such as that which is offered to refugees. The constitutions of many African countries do not recognise social protections as a fundamental human right. The International Labour Organization's (ILO) Convention 102 has not been ratified by many African countries.

Social insurance schemes inherited from the colonial governments (mainly provident funds) were established primarily for civil servants. Over the years, these schemes have transformed into mandatory national pension schemes for formal sector workers. The emphasis on the formal sector in the provision of social protection in Africa excludes rural dwellers and women who are concentrated in the informal sector. Although some social protection programmes target female-headed households, »gender is rarely used as a differentiating lens through which to understand poor people's exposure to risk and vulnerability and to design social protection measures accordingly« (Thakur et al. 2009: 167).

As part of the colonial legacy, social security institutions in Africa have largely provided old age pensions, incapacity, and survivors' benefits. In most countries, paid sick leave, paid maternity leave, and work injury leave have been mandated employer-liabilities by the labour laws. The provision of maternity leave in the formal sector as an employer-liability appears to have negative consequences for women. Maternity benefits are deemed unnecessary costs for business. As a result, many women are denied employment opportunities, and hence access to social security. A few countries such as South Africa and Namibia as well as Francophone African countries such as Benin, Guinea, Niger, and Togo provide some exceptions. The social security schemes in these countries fully or partly fund maternity leave benefits.

In some countries, harsh conditions are entrenched in labour laws to minimise the supposed negative impacts of maternity leave on enterprises. For instance, in Malawi women can qualify for maternity leave again only three years after their previous confinement. In other words, women who give birth within three years after their previous confinement lose maternity benefits. In Niger, where maternity leave benefits are split between the employer and the Caisse Nationale de Securité Sociale (CNSS), the claimant must have worked for a minimum of two years for the employer to qualify for the employer's share of the benefits. Zambia's labour laws enforce 120 days of paid maternity leave on employers for women who have been engaged for a minimum of two years. In Botswana, maternity leave is granted with full salary for the first three confinements at compulsory two year intervals. Women on their fourth confinement and above earn maternity leave at a reduced salary.[2] On average, the maternity leave period on the continent ranges from 10 to 14 weeks.

Universal family benefits are almost rare on the continent. The care of children continues to be the responsibility of both parents, but evidence of men neglecting their responsibilities abound. The judiciary is supposed to enforce child care responsibilities on fathers. However, slow justice processes, corruption, and administrative bottlenecks leave many women struggling alone with the care of their children. Middle-income countries such as Botswana, Mauritius, Namibia, and South Africa provide family benefits through state-financed social assistance programmes. In Togo, Benin, and Niger, family benefits are provided through the membership-based CNSS, but the beneficiaries are largely formal sector workers. In Togo, insured single mothers are even discriminated against. While up to six children of an insured male worker qualify for family benefits (regardless of the

2. Government employees receive 50 per cent of their salaries, while private sector employees earn 25 per cent.

wive's employment status), only two children of an insured single mother are eligible. Wives in Benin need the consent of their husbands to access family benefits.

Out-of-pocket health care service-delivery in many Africa countries is taking a great toll on women. Gabon, Ghana, and Kenya have instituted universal health insurance schemes. Mutual health schemes, usually community-based, have also evolved in countries such as Rwanda, Benin, Senegal, and Tanzania. Mutual health schemes are improving access to health care services by informal sector workers and those living in rural populations. However, affordability is cited as the main reason for the lack of enrolment in these types of schemes for the poor.[3] There are few progressive policies such as the free maternal care policy (prenatal and post-natal) instituted by the Government of Ghana through the National Health Insurance Scheme. Other countries provide free/subsidised Caesarean services (e.g., Togo, Benin, and Sierra Leone) to women on confinement. South Africa, Malawi, Mauritius, and Uganda also pursue free and universal health care delivery through public hospitals and clinics to all citizens. But access in some of these countries, particularly in Malawi and Uganda, is described as poor due to inadequate resources and geographical challenges.

Some social protection programmes on the continent have inherent positive discriminative objectives in favour of women. The Malawi Social Action Fund (MASAF) Public Works Programme (PWP) operates in food-deficient rural areas and targets women and female-headed households The programme purposely selects projects that either attract a large proportion of women workers or create assets that benefit women directly, such as woodlots and water points that reduce women's workloads and water-collection times (Cammack 1996; Shaba, unpublished). It is important to note that public work programmes may not be an effective intervention for vulnerable people, such as women involved in intensive care of children, old people, or people with disabilities. This is because PWP relies on recipients' abilities to engage in active economic activities.

A programme to feed the vulnerable in Botswana distributes free meals and nutritional supplements to pregnant women and lactating mothers from poor or low-income households. In Ghana, the Livelihood Empowerment against Poverty, a cash-transfer programme, identifies a carer for eligible persons within a household – this is usually a woman. Female-headed households have priority access to the cash transfer scheme piloted in Malawi (CTS March 2009 Monthly Monitoring Report; Shaba, unpublished). Designated caregivers of beneficiaries of the South African Child Support Grant are largely females (Agüero et al. 2006). Women in Benin receive higher retirement incomes and enjoy a tax credit based on the number of children they have.

4. Promoting Gender Justice and Poverty Alleviation through Social Protection in Africa

Unlike the developed world, where adequate social assistance programmes exist, vulnerability in most African countries has been exacerbated by the global crisis. As caregivers, women in particular have been affected by the food crises. The potential of social protection mechanisms to provide effective remedies to poverty and vulnerability – particularly in the period of post-financial and economic crisis – is not in doubt. In the African context, however, the dynamics of social protection needs to change to become more effective. So far, employment-based schemes have favoured men more than women due to labour market disaggregation and other factors such as women's biological and social roles.

Because girls' enrolment and retention in school in most African countries lags behind that of men, women in Africa are more likely than men to be unemployed due to limited skills. Women are also more likely to exit from employment to assume maternal roles. These facts are illustrated by high unemployment among women in many parts of Africa. As a result, pursuance of employment-based social protection systems would only produce or perpetuate gender inequality.

Attention to gender in designing social protection programmes can enhance efficiency and ensure better protection of men and women (Luttrell and Moser 2004: 2). Evidence suggests that gender equality is key to improving maternal health and child mortality (Luttrell and Moser 2004: 3). This is particularly so in African societies, where the traditional role of women as caregivers remains strong. For instance, women are associated

3. The 2008 Citizens Assessment of the National Health Insurance Scheme in Ghana found affordability to be the main cause of non-enrolment in the scheme.

with prioritising health care expenditures. Women also show a greater propensity to spend money in health-related matters such as nutrition, as compared with men (Khander 1998). In a case study about Mutual Health Organisations (MHO) in Mali, Senegal, and Ghana, Chankova et al. (2008) found that female-headed households are more likely to join mutual health organisations than male-headed households. Such evidence provides justification that social protection programmes targeting women can have a significant positive impact on living conditions.

The traditional African dependency culture means that social benefits have a broader impact on an extended family, if not the larger community. Olivier and Kalula (2004) noted in South Africa that recipients of »Older Persons« grants tend to share their meagre incomes with family members in need, particularly when there are no other ongoing sources of income. Old age pensions in South Africa have had a particularly positive effect on girls' nutritional status – those in recipient households are on average 3 to 4 centimetres taller than their same-age counterparts in non-recipient households (Samson et al. 2004).

Undoubtedly, having women beneficiaries of social grants as caregivers would facilitate the trickle-down in benefits to other family members. Cash transfers in the hands of women as caregivers can improve children's health and nutritional status as well as school enrolment. Baird et al. (2009) observed from a conditional cash-transfer experiment among teenage girls and young women in Malawi that a rise in re-enrolment rates among dropouts increased by two and a half times, while the dropout rate among those in school decreased from 11 to 6 per cent.

Giving women access to productive resources through social grants or public work programmes also means empowering them economically and teaching them to be self-reliant. Posel et al. (2006) found that households receiving social grants offer better chances to age-qualified female members undertaking a job search, resulting in greater success in securing employment. Addressing gendered forms of vulnerability across the life cycle can lead to gains in gender equity, poverty reduction, and human development. Well-designed programmes that account for the synergies between women's work and children's welfare and recognise the barriers to women's advancement in the labour market offer a strong potential to contribute to wider goals of economic growth, human development, and social justice (Thakur et al. 2009: 169).

Giving women in the formal sector in Africa access to unconditional maternity benefits through public social security schemes can boost women's career development. This may alleviate the fears of private businesses about high maternity costs associated with young women. For those in the informal sector, universal family benefits and access to free health care (maternal, including child care) would also be the surest way of supporting women to meet gender-imposed vulnerabilities. Special tax incentives can also be instituted for single mothers in the formal sector.

Studies have established that countries need not be rich to afford social protection programmes, but African governments continue to hide behind excuses about affordability to evade responsibilities. Sub-Saharan Africa has the lowest levels of expenditure for social protection after South Asia. In some countries such as Ghana and Namibia, cash transfers have been condemned as a medium to encourage laziness and dependency, although pilot programmes had shown significant improvements in the lives of beneficiaries, in social as well as economic terms.

However, it is important to note that the current highly informal structure of many sub-Saharan African countries offers little room for universal social protection schemes. Social security schemes supported by the few formal sector workers are not sustainable in the long term. Poor tax regimes have resulted in high donor dependency. So far, pilot cash-transfer programmes on the continent are financed by donors. African countries need to explore appropriate financing mechanisms. It is difficult to sustain universal coverage without mandating contributions, either through taxes or insurance. With high poverty levels, taxes (on luxury goods) appear to be an appropriate mechanism to ensure that the poor are paid for by the rich. In Ghana, a 2.5 per cent tax on goods and services to finance the National Health Insurance Scheme has proven to be viable. In 2009, the National Health Insurance Levy in Ghana provided 61.7 per cent of the National Health Insurance Scheme's revenues. Consequently, the Government of Ghana is considering eliminating premiums to ensure universal access

to health care. In 2009, Gabon raised 30 million US dollars for health by partly imposing a 1.5 per cent tax on companies handling remittances from abroad.[4] Similar mechanisms, when well-established, can boost cash-transfer financing and promote wider coverage.

4. »The Challenge of Improving Access through Effective Health Care Financing«. A presentation by David B. Evans, the Director of Health Financing Systems, World Health Organisation at the Swiss TPH Spring Symposium on 5 April 2011.

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